Complete Summary

GUIDELINE TITLE

Preventive health care, 1999 update. Follow-up after breast cancer.

BIBLIOGRAPHIC SOURCE(S)

Temple LK, Wang EE, McLeod RS. Preventive health care, 1999 update: 3. Follow-up after breast cancer. Canadian Task Force on Preventive Health Care. CMAJ 1999 Oct 19;161(8):1001-8. [50 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Breast cancer

GUIDELINE CATEGORY

Evaluation
Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Oncology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel

Nurses
Physician Assistants
Physicians
Students

GUIDELINE OBJECTIVE(S)

To make recommendations to physicians who provide follow-up care for women who have been treated for early-stage breast cancer.

TARGET POPULATION

Women who have been treated for early-stage breast cancer.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Combination of blood tests, bone scans, liver echography and chest radiography for detection of distant disease
2. Physical examination with or without mammography for detection of contralateral breast cancer
3. Physical examination with or without mammography for detection of ipsilateral recurrent disease after breast-conserving therapy

MAJOR OUTCOMES CONSIDERED

- Survival, disease recurrence and quality-of-life measures for distant disease
- Local recurrence of disease
- Disease in the contralateral breast

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Before performing a literature search, the guideline developers developed the following inclusion criteria: women must have had stage I to III infiltrating ductal adenocarcinoma of the breast; there was no clinical evidence of distant disease at the time of diagnosis; when appropriate, adjuvant therapy, if received, was described; and the women were followed up for at least 5 years.

On consultation with a medical librarian, the guideline developers performed a MEDLINE (U.S. National Library of Medicine) search of the English-language literature from January 1966 to January 1998 combining the MeSH (medical subject headings) terms "breast neoplasms" and "neoplasm recurrence" (local and distant), with limits to "human." To determine the sensitivity of mammography

after local excision, the guideline developers performed a MEDLINE search from 1966 to 1998 combining the MeSH headings "breast neoplasms," "neoplasm recurrence," "local/diagnosis" and "mammography." Reference lists of retrieved articles were reviewed. Two breast cancer specialists were then consulted to ensure the completeness of the literature search.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of evidence was rated according to 5 levels:

I - Evidence from at least 1 properly randomized controlled trial.

II-1 - Evidence from well-designed controlled trials without randomization.

II-2 - Evidence from well-designed cohort or case-control analytic studies, preferably from more than 1 centre or research group.

II-3 - Evidence from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments could also be included here.

III - Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The task force of expert clinician/methodologists from a variety of medical specialties used a standardized evidence-based method for evaluating the

effectiveness of this intervention. Procedures to achieve adequate documentation, consistency, comprehensiveness, objectivity and adherence to the task force method were maintained at all stages during review development, the consensus process and beyond.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation:

A. Good evidence to support the recommendation that the condition or maneuver be specifically considered in a periodic health examination.
B. Fair evidence to support the recommendation that the condition or maneuver be specifically considered in a periodic health examination.
C. Insufficient evidence regarding inclusion or exclusion of the condition or maneuver in a periodic health examination, but recommendations may be made on other grounds.
D. Fair evidence to support the recommendation that the condition or maneuver be specifically excluded from a periodic health examination.
E. Good evidence to support the recommendation that the condition or maneuver be specifically excluded from a periodic health examination.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The findings of this analysis were reviewed through an iterative process by the members of the Canadian Task Force on Preventive Health Care. It was then peer reviewed as part of the journal publication process. Under the auspices of the Italian Ministry of Health and the Italian Research Council, an Italian group of stakeholders met in 1994 and recommended that yearly mammography and physical examination every 3 months be done for the first 2 years, yearly mammography and physical examination every 6 months be done for the next 3 years, and yearly mammography and physical examination be done thereafter. Within Canada, a consensus document recommended frequent physical examination and yearly mammography, although the authors acknowledged that their recommendations were extrapolated from findings in the general population. Thus, the proposed guidelines differ with respect to the strength of recommendations concerning the role of mammography and physical examination in the follow-up of local recurrence and contralateral breast cancer.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendation grades [A, B, C, D, E] and levels of evidence [I, II-1, II-2, II-3, III] are indicated after each recommendation. Definitions for these grades and levels are repeated following the recommendations.

- There is good evidence from well-designed randomized controlled trials that there is no difference in survival or quality of life with laboratory or diagnostic screening as compared with physical examination for distant disease (Rosselli et al., 1994; Impact of follow-up testing on survival and health-related quality of life in breast cancer patients, 1994). Therefore, laboratory or diagnostic screening, or screening with both methods, for distant disease is not indicated (E, I).
- Ipsilateral (local) recurrence after breast-conserving therapy was not shown to affect survival in randomized controlled trials comparing various surgical and radiotherapy treatments in which follow-up included frequent physical examination and mammography of all women (Level I) (Fisher et al., 1995; Liljegren et al., 1994; Clark et al., 1996; Veronesi et al., 1995; Forrest et al., 1996; Van Dongen et al., 1992). However, the unique role of early detection in the ipsilateral breast by physical examination and mammography is unknown (C, III).
- There is some evidence (level II-3 [Gutter, 1976; Senofsky et al., 1986] and level II-2 [Mellink et al., 1991]) that mammography of the contralateral breast identifies second primary cancers at an earlier stage than does physical examination. However, in an underpowered secondary analysis of a randomized controlled trial comparing radical mastectomy with modified mastectomy and radiation, contralateral breast cancer, when detected by physical examination, was not shown to affect survival at 10 years (level II-2) (Fisher et al., 1984). Screening with yearly mammography and physical examination has been included in the protocols of randomized controlled trials and is recommended by experts (level III). Although there is indirect evidence suggesting that there may be a clinical benefit, there is no direct evidence to support the inclusion or exclusion of the maneuver in the follow-up of women with breast cancer (C, III).

Definitions:

Recommendation Grades:

A. Good evidence to support the recommendation that the condition or maneuver be specifically considered in a periodic health examination (PHE).
B. Fair evidence to support the recommendation that the condition or maneuver be specifically considered in a PHE.
C. Poor evidence regarding inclusion or exclusion of the condition or maneuver in a PHE, but recommendations may be made on other grounds.
D. Fair evidence to support the recommendation that the condition or maneuver be specifically excluded from consideration in a PHE.
E. Good evidence to support the recommendation that the condition or maneuver be specifically excluded from consideration in a PHE.

Levels of Evidence:

I - Evidence from at least 1 properly randomized controlled trial (RCT).

II-1 - Evidence from well-designed controlled trials without randomization.

II-2 - Evidence from well-designed cohort or case-control analytic studies, preferably from more than 1 centre or research group.

II-3 - Evidence from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments could also be included here.

III - Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Maneuver: Blood work and diagnostic imaging
Level of Evidence:
Two randomized controlled trials (I)

Maneuver: Follow-up for local recurrence
Level of Evidence:
Expert opinion (III) from follow-up protocols of randomized controlled trials comparing mastectomy with or without radiotherapy

Maneuver: Follow-up for contralateral breast cancer
Level of Evidence:
Expert opinion (III) from follow-up protocols of randomized controlled trials comparing mastectomy with or without radiotherapy and data from general population

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Breast cancer is the most common cancer in Canadian women and is the second leading cause of death after lung cancer. Even with early-stage breast cancer, recurrence after treatment for primary breast cancer is frequent. Traditionally, follow-up has been felt to facilitate early detection and improve survival and quality of life.

POTENTIAL HARMS

There were no negative consequences of screening with respect to quality of life.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation of preventive activities in clinical practice continues to be a challenge. To address this issue, Health Canada established a National Coalition of Health Professional Organizations in 1989. The purpose was to develop a strategy to enhance the preventive practices of health professionals. Two national workshops were held. The first focused on strengthening the provision of preventive services by Canadian physicians. The second addressed the need for collaboration among all health professionals. This process led to the development of a framework or "blueprint for action" for strengthening the delivery of preventive services in Canada (Supply and Services Canada: an Inventory of Quality Initiatives in Canada: Towards Quality and Effectiveness. Health and Welfare Canada, Ottawa, 1993). It is a milestone for professional associations and one that will have a major impact on the development of preventive policies in this country.

In 1991 the Canadian Medical Association spearheaded the creation of a National Partnership for Quality in Health to coordinate the development and implementation of practice guidelines in Canada. This partnership includes the following: the Association of Canadian Medical Colleges, the College of Family Physicians of Canada, the Federation of Medical Licensing Authorities of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Council on Health Facilities Accreditation, and the Canadian Medical Association.

The existence of guidelines is no guarantee they will be used. The dissemination and diffusion of guidelines is a critical task and requires innovative approaches and concerted effort on the part of professional associations and health care professionals. Continuing education is one avenue for the dissemination of guidelines. Local physician leaders, educational outreach programs, and computerized reminder systems may complement more traditional methods such as lectures and written materials.

Public education programs should also support the process of guideline dissemination. In this context, rapidly expanding information technology, such as interactive video or computerized information systems with telephone voice output, presents opportunities for innovative patient education. The media may also be allies in the communication of some relevant aspects of guidelines to the public. All of these technologies should be evaluated.

The implementation of multiple strategies for promoting the use of practice guidelines requires marshaling the efforts of governments, administrators, and health professionals at national, provincial and local levels. It is up to physicians and other health professionals to adopt approaches for the implementation of guidelines in clinical practice and to support research efforts in this direction.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Temple LK, Wang EE, McLeod RS. Preventive health care, 1999 update: 3. Follow-up after breast cancer. Canadian Task Force on Preventive Health Care. CMAJ 1999 Oct 19;161(8):1001-8. [50 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999

GUIDELINE DEVELOPER(S)

Canadian Task Force on Preventive Health Care - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

The Canadian Task Force on Preventive Health Care is funded through a partnership between the Provincial and Territorial Ministries of Health and Health Canada.

GUIDELINE COMMITTEE

Canadian Task Force on Preventive Health Care (CTFPHC)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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Members: Drs. R. Wayne Elford, Professor and Chair of Research, Department of Family Medicine, University of Calgary, Calgary, Alta.; Michel Labrecque, Associate Professor and Director of Research, Department of Family Medicine and Centre Hospitalier Universitaire de Québec, Laval University, Quebec, Que.; Robin McLeod, Professor, Department of Surgery, Mount Sinai Hospital and University of Toronto, Toronto, Ont.; Harriet MacMillan, Associate Professor, Departments of Psychiatry and Pediatrics and Centre for Studies of Children at Risk, McMaster University, Hamilton, Ont.; Jean-Marie Moutquin, Professor, Department of Obstetrics and Gynecology and Saint-François d'Assise Research Centre, Laval University, Quebec, Que.; Christopher Patterson, Professor and Head, Division of Geriatric Medicine, Department of Medicine, McMaster University, Hamilton, Ont.; Elaine E.L. Wang, Associate Professor, Departments of Pediatrics and Public Health Sciences, Faculty of Medicine, University of Toronto, Toronto, Ont.

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

A complete list of planned reviews, updates and revisions is available under the What's New section at the CTFPHC Web site.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Canadian Task Force on Preventive Health Care (CTFPHC) Web site.

Print copies: Available from Canadian Task Force on Preventive Health Care, 100 Collip Circle, Suite 117, London, Ontario N6G 4X8, Canada.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Stachenko S. Preventive guidelines: their role in clinical prevention and health promotion. Ottawa: Health Canada, 1994. Available from the Canadian Task Force on Preventive Health Care (CTFPHC) Web site.

- CTFPHC history/methodology. Ottawa: Health Canada, 1997. Available from the CTFPHC Web site.
- Quick tables of current recommendations. Ottawa: Health Canada, 2000. Available from the CTFPHC Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on March 24, 2001. The information was verified by the guideline developer as of June 1, 2001.

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